

# REFERRAL AND PRESCRIPTION FORM



Patient: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex:  Male  Female  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Daytime Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_  
Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Sleep Study

**DX: Rule Out 327.23 OSA**

Overnight Pulse Oximetry

AutoPAP Trial x \_\_\_\_\_ days  
\_\_\_\_\_ min. cwp \_\_\_\_\_ max. cwp

**DX: 327.23 OSA**

Download Compliance

Download AHI

CPAP/BiPAP/AutoPAP with Heated Humidity

Qualifying data:

**DX: 327.23 OSA**

The prescription is for:

AHI: \_\_\_\_\_

CPAP @ \_\_\_\_\_ cwp

Test date: \_\_\_\_\_

BiPAP @ \_\_\_\_\_ cwp IPAP/ \_\_\_\_\_ cwp EPAP

**\*\*\* Please include sleep study with this order \*\*\***

Backup rate of \_\_\_\_\_ (if required)

Mask - Full Face

Mask - Nasal

AutoPAP @ \_\_\_\_\_ cwp min/ \_\_\_\_\_ cwp max

Headgear

Filters

Download Compliance data in \_\_\_\_\_ weeks

Cushions

Tubing

Download AHI data in \_\_\_\_\_ weeks

Pillows

Water Chamber

Refill Quantity on Supplies: 12 (1/mo.)

Comments: \_\_\_\_\_  
\_\_\_\_\_

Physician Signature

NPI#

Date

**\*\*\* Please fax all insurance information and patient demographics with this order sheet. \*\*\***

**Phone: 262-522-0606 Fax To: 262-522-0808**